

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06811

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06810

1. DECEASED-NAME (Type or Print) Frank Xavier Armstrong			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 5-13-69 19 11-30AM		
3. SEX Male	4. RACE W-US	5. DATE OF BIRTH 6-30-1903	6. AGE (In years full birthday) 66 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN 0
7a. BIRTHPLACE (State or foreign country) Washington D.C. USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Indian Head Md			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 30 Cypress Place		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Govt. Emp.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Charles	13c. CITY OR TOWN Indian Head	13d. STREET AND NUMBER 28-Cypress Place
14. FATHER'S NAME First Middle Last Ambrose Armstrong			15. MOTHER'S MAIDEN NAME First Middle Last Mary A.O'Donnell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. USCG. 214-52-3722		17. INFORMANT ADDRESS Miss Regina O'Donnell Aunt. Indian Head Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4109 IMMEDIATE CAUSE (a) Coronary Occlusion Massive DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis General DUE TO, OR AS A CONSEQUENCE OF (c) Aging Process					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate Indefinite
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James E. Andrews		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 5-13-69	
EXAMINER'S NAME (Type) James E. Andrews MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-16-1969		23c. NAME OF CEMETERY OR CREMATORY Resurrection	
24. FUNERAL DIRECTOR William G. 131-11th St. S.E. Wash. D.C.		23d. LOCATION (City or Town) (County) (State) Clinton Pr. George Md		25a. REC'D BY REGISTRAR MAY 15 1969	
25b. REGISTRAR'S SIGNATURE Charles Judge					

12228

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2509

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR					
Robert L. Beasley						Month	Day	Year	9-30A.M.					
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		7. IF UNDER 1 YEAR						
Male	White		6-2-98			70 YRS.		MONTHS DAYS HOURS MIN.						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH								
Georgia		U.S.				Charles Md.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY						
La Plata		Physicians Memorial Hosp.				Machinist		U.S. Govt.						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
Md.			Charles		Waldorf		YES		202 Parksdale Ave.					
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last			
Wylie					Beasley	Rosa					Cone			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address					
Yes			1919-1921 577-58-2376			Gladys I. Beasley			202 Parksdale Ave. Waldorf, Md.					
8. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) Pneumonia (R).														
DUE TO, OR AS A CONSEQUENCE OF														
(b) Diabetes Mellitus.														
DUE TO, OR AS A CONSEQUENCE OF														
and (c) Cerebra Vascular insufficiency.														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
Old Myocardial infarction.														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. Month Day Year												
(If either, notify medical examiner)		P.M. 19												
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION		Street or R.F.D. No.		City or Town		County		State	
While <input type="checkbox"/> Not while <input type="checkbox"/>														
at work <input type="checkbox"/> at work <input type="checkbox"/>														
22a. I certify that (I) (this hospital) attended the deceased from 4/26, 1969, to 5/12/1969, that (I) (we) last saw the deceased alive on 5/12/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE										22c. DATE SIGNED				
Niren N. Bhaduri										9/13/69				
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS				
Niren N. Bhaduri										Waldorf, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County)		(State)			
Burial		May 14, 1969		Cedar Hill			Suitland		B. Geo.		Md.			
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
The Hunt Funeral Home		Waldorf, Md.			MAY 15 1969		F. J. [Signature]							

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

FOR STATE
HEALTH DEPT.

06813

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06812

1. DECEASED NAME (Type or Print) GEORGE WILLIAM BRANDT			2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 5 21 1969			2b. HOUR 6:00 M
3. SEX MALE	4. RACE CAU.	5. DATE OF BIRTH OCT. 19, 1883	6. AGE (in years last birthday) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD Month 5 Day 21 Year 1969 2d. HOUR 6:00 M
7a. BIRTHPLACE (State or foreign country) GERMANY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CHARLES Md.
10. CITY OR TOWN OF DEATH WALDORF		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RFD 1		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PRINTER		12b. KIND OF BUSINESS OR INDUSTRY PAPER
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY CHARLES WALDORF		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER RFD 1
14. FATHER'S NAME First Middle Last GEORGE BRANDT			15. MOTHER'S MAIDEN NAME First Middle Last MARIE HENNINGMANN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 577-03-2857		17. INFORMANT 4706 ADAMS ST. STONE AVE. GEORGE F. BRANDT, CHEVY CHASE, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7. bullet wound of 955X CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) accident DUE TO, OR AS A CONSEQUENCE OF (c) self-inflicted APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-21-69						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 5-21 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Suicide		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. City or Town County State Valley Chase Md		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE E. J. EDELEN		EXAMINER'S NAME (Type) E. J. EDELEN M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 5-21-69
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5-24-69		23c. NAME OF CEMETERY OR CREMATORY PROSPECT HILL CEM.		23d. LOCATION (City or Town) (County) (State) WASHINGTON, D.C.
24. FUNERAL DIRECTOR HUNT FUNERAL HOME, WALDORF, MD.				25a. REC'D BY REGISTRAR DATE MAY 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, M.D. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

000000

UNITED STATES DEPARTMENT OF AGRICULTURE

WASH DC

TO THE SECRETARY OF AGRICULTURE
FROM THE DIRECTOR OF THE BUREAU OF PLANT INDUSTRY
SUBJECT: [Illegible]
[Illegible text follows, appearing to be a memorandum or report.]

MAY 2 1933

FOR STATE
HEALTH DEPT.

06814

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06813

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) JOSEPH WILLIS FARMER		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 3 Day 15 Year 69		2b. HOUR 10 P.M.
3. SEX MALE	4. RACE Negro	5. DATE OF BIRTH 8-30-09	6. AGE (In years) 59 YRS	7. UNDER 1 YEAR MONTHS _____ DAYS _____
7a. BIRTHPLACE (State or foreign country) Newport, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Charles
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Route 225		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Charles	13c. CITY OR TOWN La Plata	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First Joseph Middle Farmer		15. MOTHER'S MAIDEN NAME First Lucy Middle Hawkins		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 212-12-2208		17. INFORMANT Mrs. Louise Queen-Sister Wash., D.C.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-15-69				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year _____ P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE E.J. Edelen		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 5-16-69
EXAMINER'S NAME (Type) E.J. Edelen, M.D. La Plata, Md.		23. ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, or other disposition Burial	23b. DATE 5/19/1969	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery	23d. LOCATION (City or Town) (County) (State) La Plata, Md.	
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md.		25a. REC'D BY REGISTRAR MAY 21 1969		25b. REGISTRAR'S SIGNATURE Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a summary of the work done and is intended to give a general impression of the work done and the progress made.

2. The second part of the report deals with the results of the work done during the year. It is a summary of the results of the work done and is intended to give a general impression of the results of the work done and the progress made.

3. The third part of the report deals with the conclusions drawn from the work done during the year. It is a summary of the conclusions drawn from the work done and is intended to give a general impression of the conclusions drawn from the work done and the progress made.

4. The fourth part of the report deals with the recommendations made during the year. It is a summary of the recommendations made during the year and is intended to give a general impression of the recommendations made during the year and the progress made.

5. The fifth part of the report deals with the summary of the work done during the year. It is a summary of the work done during the year and is intended to give a general impression of the work done during the year and the progress made.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06815

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06814

1. DECEASED-NAME (Type or print) GRACE LUCILLE GAMBLE			2a. DATE OF DEATH Month 4 Day 19 Year 69		2b. HOUR M
3. SEX F	4. RACE W	5. DATE OF BIRTH MAY 22, 1894		6. AGE (In years last birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH CHARLES		
10. CITY OR TOWN OF DEATH LA PLATA	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PHYSICIANS MEM. HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWORK		12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.	13b. COUNTY CHARLES	13c. CITY OR TOWN WHITE PLAINS	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME First WILLIAM Middle W. Last WILKERSON		15. MOTHER'S MAIDEN NAME First FRANCES Middle GENEVA Last ROBEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. ←		17. INFORMANT DOROTHY WEDDING, PORT TOBACCO, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis - chronic. DUE TO, OR AS A CONSEQUENCE OF Uterine Cancer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 1 year?
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes.
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4-18, 1969 , to 5-4, 1969 , that (I) (we) last saw the deceased alive on 5-4, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE F. M. JOHNSON		DEGREE F. M. JOHNSON MD.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 5-4-69
22d. PHYSICIAN'S NAME (Type) F. M. JOHNSON MD.		22e. ADDRESS LA PLATA, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 5-7-69	23c. NAME OF CEMETERY OR CREMATORY TRINITY MEN. GARDENS		23d. LOCATION (City or Town) (County) (State) WALDORF, CHARLES, MD.	
24. FUNERAL DIRECTOR HUNT FUNERAL HOME, WALDORF, MD.		25a. REC'D BY REGISTRAR MAY 12 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1/69

06816		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06815	
CERTIFICATE OF DEATH							
1. DECEASED NAME (Type or print) <i>Sankston</i> First <i>Walter</i> Middle <i>JACKSON</i> Last			2a. DATE OF DEATH <i>May</i> Month <i>28</i> Day <i>1969</i> Year			2b. HOUR <i>2 P</i> M	
3 SEX <i>Male</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>Nov. 7, 1884</i>		6. AGE (In years last birthday) <i>84</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>CHARLES</i> Md	
10. CITY OR TOWN OF DEATH <i>La Plata</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>D.O.A. Physicans Mem. Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done most of time, even if retired) <i>Farmer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Charles</i>		13c. CITY OR TOWN <i>Tompkinsville</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/>	
14. FATHER'S NAME First <i>Walter L.</i> Middle <i>Jackson</i> Last		15. MOTHER'S MAIDEN NAME First <i>Elsie V.</i> Middle <i>Stine</i> Last <i>Susan Bailey</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <i>212-18-8534</i>		17. INFORMANT Address <i>Tompkinsville, Md.</i> <i>Mrs. Elsie V. Stine-Daughter</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial infarction</i>							<i>1 mi</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <i>4104</i>							
(b) <i>Coronary artery disease</i>							<i>7 yrs</i>
(c) <i>Generalized arteriosclerosis</i>							<i>10 yrs</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Diahts</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1955</i> , 19____, to <i>28 May 1969</i> , that (I) (we) lost the deceased alive on <i>28 May 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Arthur O. Woody</i> MD DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>29 May 1969</i>	
22d. PHYSICIAN'S NAME (Type) <i>ARTHUR O. WOODY, M.D.</i>				22e. ADDRESS <i>LA PLATA, MARYLAND</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>5/31/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Ghost Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Issue, Maryland</i>	
24. FUNERAL DIRECTOR <i>Arehart Funeral Home, Inc. - La Plata, Md.</i>				25a. REC'D BY REGISTRAR <i>JUN 3 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06817 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06816

1 DECEASED NAME (Type or Print) John Wesley Jenifer			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 5 - 7 - 1959 Year 19			2b HOUR 12-00 MIN 00			
3 SEX Male	4 RACE Negro	5 DATE OF BIRTH 12-27-1908	6 AGE (In years last birthday) 60 YRS	IF UNDER 1 YEAR MONTHS 00 DAYS 00	IF UNDER 24 HRS. HOURS 00 MIN 00	2c DATE PRONOUNCED DEAD Month 5 - 7 - 1959 Day 19 Year 19 12- 10 00			
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Charles County Md.			
10 CITY OR TOWN OF DEATH LaPlata Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Physicians Memorial LaPlata Md.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farmer		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Charles		13c. INSIDE CITY LIMITS? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		13e STREET AND NUMBER 101-1011		
14 FATHER'S NAME Frank Jenifer			15 MOTHER'S MAIDEN NAME Florence Plater						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b SOCIAL SECURITY NO 218-03-4325		17 INFORMANT Sarah Aydelotte-Sister-LaPlata Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion-Massive DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate Indefinite									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A M 19 P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. Indian Head Rd City or Town Charles County County Charles County State (State)					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE James E. Andrews			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED 5-7-69			
EXAMINER'S NAME (Type) James E. Andrews			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) Indian Head Rd Charles County			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 5/10/1969		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d LOCATION (City or town) (County) (State) Newport, Maryland			
24 FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md.			ADDRESS Arehart Funeral Home, Inc.-La Plata, Md.			25a REC'D BY REGISTRAR MAY 14 1969		25b REGISTRAR'S SIGNATURE 17	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
06818					06817					
1. DECEASED NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR			
Jennie Simms Jenkins					May 24 1969		10 04 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Female		Caucasian		Nov. 26, 1886		82 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				CHARLES Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
La Plata			303 Spruce Street			Home Maker				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, A.M. 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Charles		La Plata		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		303 Spruce Street	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last					
FRANK P. JENKINS					M. Bertha Simms					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
No			Unknown		Mr. Louis P. Jenkins-Nephew-La Plata Md.					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Circulatory Failure									3 hrs	
DUE TO OR AS A CONSEQUENCE OF (b) Cardiac Failure									2 days	
DUE TO OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular Disease									Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from 30 Apr 1969, to May 24 1969, that (I) (we) last saw the deceased alive on May 24 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE J. Barry Mason M.D.					DEGREE ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 24 May 69			
22d. PHYSICIAN'S NAME (Type) J.G. Barry Mason, M.D.					22e. ADDRESS La Plata, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		5/27/1969		St. Ignatius Cemetery		Bel Alton, Maryland				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Arehart Funeral Home, Inc.-La Plata, Md.					DATE JUN 2 1969		J. Charles Judge			

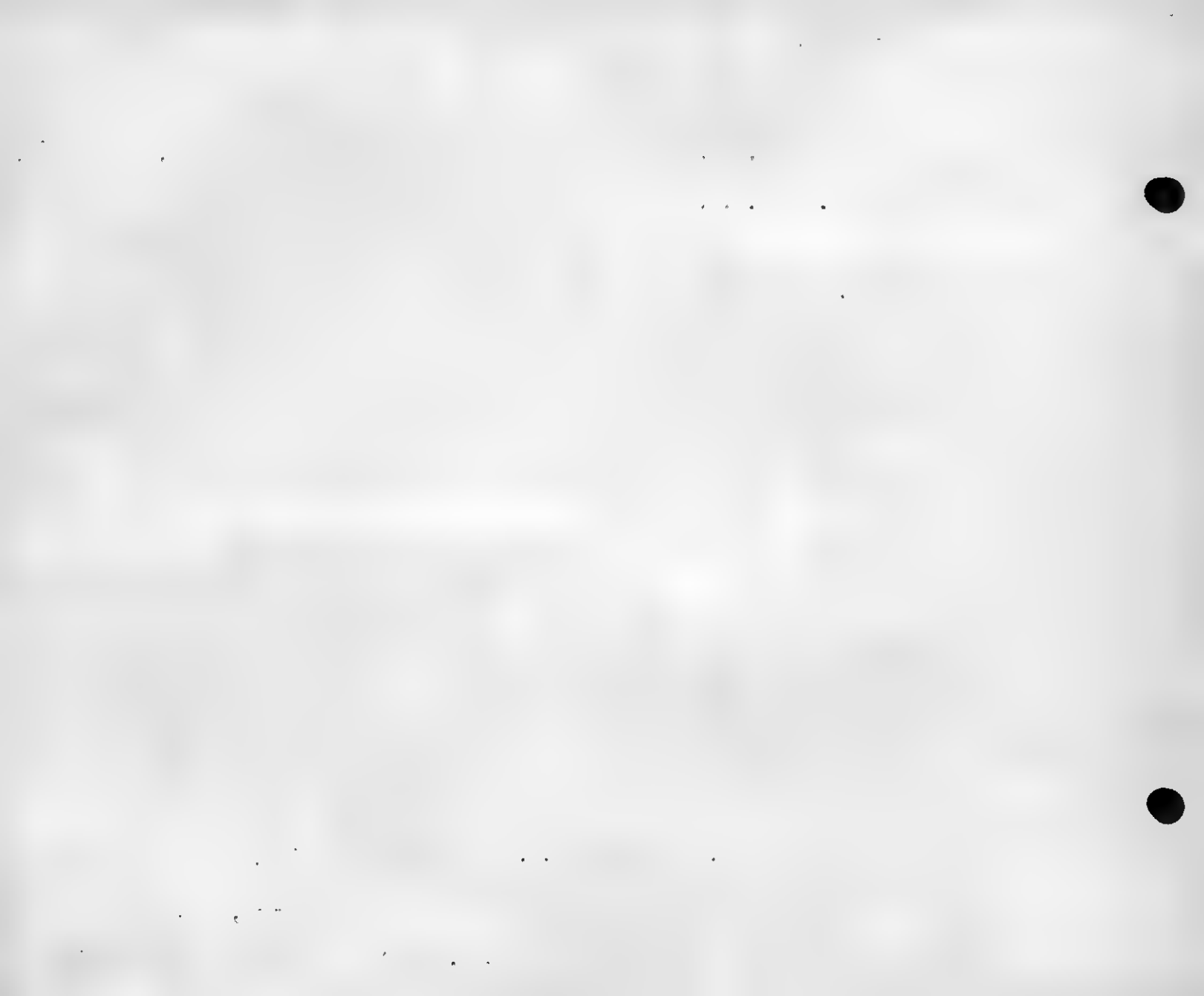


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil on Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form WM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 10 Film 4113 6/6/69 kk										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 6-17-69 ams																								
06819 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										06818																								
1 DECEASED NAME (Type or Print)					First Middle Last					2a DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year					2b HOUR																			
SAMUEL					PASCOE					May 18, 19 69					M																			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years past birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year					2d HOUR																	
Male		White		Dec. 14, 1924		44 YRS						May 18, 19 69					8:00 P.M.																	
7a BIRTHPLACE (State or foreign country)					7b CITIZEN OF WHAT COUNTRY?					8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9 COUNTY OF DEATH					Md.														
Chicago, Ill.					U.S.A.										CHARLES																			
10 CITY OR TOWN OF DEATH					11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b KIND OF BUSINESS OR INDUSTRY																			
La Plata					Arenhart Funeral Home					Physician					Private																			
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE					13b COUNTY					13c CITY OR TOWN					13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e STREET AND NUMBER														
Va.					Fairfax					Falls Church					YES <input type="checkbox"/> NO <input type="checkbox"/>					6542 Cedarwood Court														
14 FATHER'S NAME					15 MOTHER'S M.A.DEN NAME																													
Sam					Pascoe					Mary					Gladys					Lightfoot														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b SOCIAL SECURITY NO					17. INFORMANT					ADDRESS																			
Yes					Korea					400022-7042					Patricia Louise Pascoe (same as 13e)																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1 DEATH WAS CAUSED BY:																																		
IMMEDIATE CAUSE (a) Drowning																																		
DUE TO, OR AS A CONSEQUENCE OF																																		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																																		
(b) DUE TO, OR AS A CONSEQUENCE OF																																		
(c)																																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																		
19a DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b TIME OF INJURY Month, Day Year HOUR A.M. 8:45 P.M. 5-18 1969										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Fell overboard while trying to lift anchor														
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>										21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Potomac River										21f. LOCATION Street or R.F.D. No City or Town County State Freestone Point Charles Md.														
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																																		
ACTUAL SIGNATURE										Charles S. Springate M.D.										22b DATE SIGNED May 19, 1969														
EXAMINER'S NAME (Type)										Charles S. Springate, M.D.										ADDRESS (Street, city, town, or county)														
23a BURIAL, CREMATION, REMOVAL (Specify)										23b DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)				
Burial										May 21, 1969										Columbia Gardens										Arlington, Virginia				
24 FUNERAL DIRECTOR															ADDRESS										25a REC'D BY REGISTRAR					25b REGISTRAR'S SIGNATURE				
Covington-Martin Funeral Home															Falls Church, Va.										DATE MAY 22 1969					V. Charles Judge				



4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (4)
30M REV. 1/68

MIDDLE STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
06820					06819				
1. DECEASED-NAME (Type or print) James Pierce Patton					2a. DATE OF DEATH 5-22-69 Month Day Year			2b. HOUR 8:05A M	
3 SEX Male		4. RACE W-US		5. DATE OF BIRTH 6-27-1907			6. AGE (in years last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Georgia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Charles County Md			
10. CITY OR TOWN OF DEATH LaPlata Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Physicians Memorial			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Salesman			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Bryans Road		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last Leonard P. Patton				15. MOTHER'S M.A.D.E.N. NAME First Middle Last Cora B. Hall					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)				16b. SOCIAL SECURITY NO 441-08-2266		17. INFORMANT Address Hertchel L. Patton, Son, Bryans Road Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Massive. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Arterio Sclerosis General DUE TO, OR AS A CONSEQUENCE OF (c) Aging Process									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours Indefinite Indefinite
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 5-20-69 , 19____, to 5-22-69 , 19____, that (I) (we) last saw the deceased alive on 5-22-69 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James E. Andrews DEGREE MD					ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-22-69		
22d. PHYSICIAN'S NAME (Type) James E. Andrews MD					22e. ADDRESS Indian Head Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/24/1969		23c. NAME OF CEMETERY OR CREMATORY Trinity Memorial Gardens			23d. LOCATION (City or Town) (County) (State) Waldorf, Maryland		
24. FUNERAL DIRECTOR ADDRESS Arehart Funeral Home, Inc.-La Plata, Md.					25a. REC'D BY REGISTRAR MAY 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil, in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 10, 11 & 13 Film only
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06821

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06820

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year		2b. HOUR	
OTIS		MC CLARY		PEACHER, SR.				2a. DATE OF ESTI- MATED <input type="checkbox"/> May 18, 1969		M	
3 SEX	4. RACE	5. DATE OF BIRTH	6 AGE (n years last birthday)	F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR	
Male	White	11-5-1926	42 YRS					May Day 18, 1969		8:00 P.M.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md	
Virginia		U. S. A.				CHARLES					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
LAPLATA Point		Potomac River Ehrenhart Funeral House									
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Va.		Woodbridge		YES <input type="checkbox"/> NO <input type="checkbox"/>		410 G. Street					
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
J. W. Peacher								Daisey B McClary			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
WWII		228-24-0276		Cunningham Funeral Home, Alexandria, Virginia							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>1104</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. 11:45xx 5-18 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) Attempting to rescue daughter and drowned							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.) Potomac River		21f. LOCATION Street or R.F.D. No Frestone Point		City or Town Md.		County		State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Springate		Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS STANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED May 19, 1969	
EXAMINER'S NAME (Type)				ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		5-22-69		Dumphries Cemetery		Dumphries, Virginia					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Howard H. Hubbard		4107 Wilkens Ave. Baltimore		21229		MAY 21 1969					

FOR STATE
HEALTH DEPT.

1
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in line 10. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06822

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06821

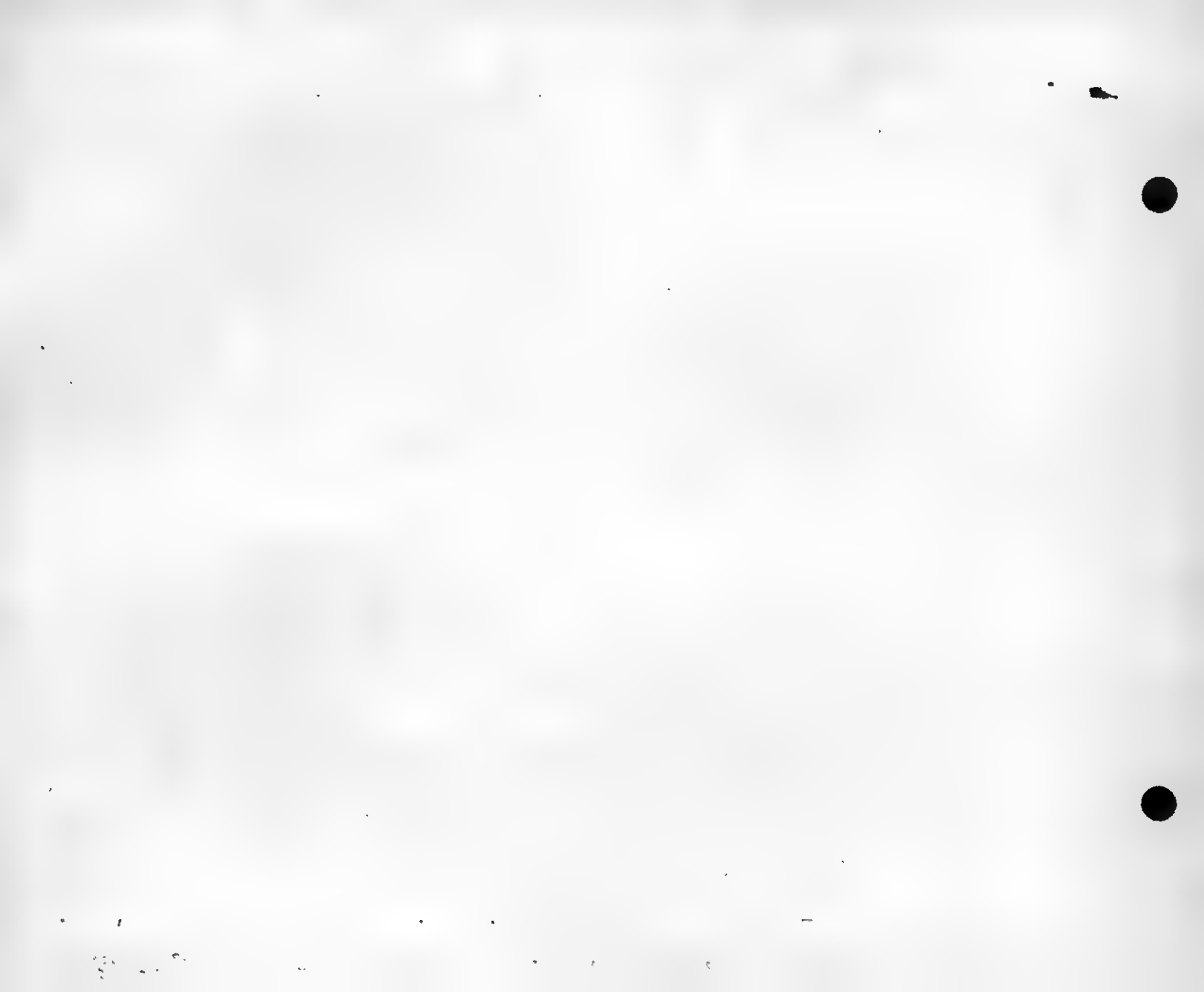
1 DECEASED NAME (Type or Print) TERESA		First DAWN		Middle Peacher		Last Peacher		2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month 5 Day 18 Year 69		2b HOUR 1:30 M	
3 SEX Female	4 RACE White	5 DATE OF BIRTH 9/1/1952	6 AGE (in years last birthday) 16 YRS	7 IF UNDER 1 YEAR MONTHS 16 DAYS 16	8 IF UNDER 24 HRS HOURS 16 MIN 16	2c DATE PRONOUNCED DEAD Month 5 Day 19 Year 69		2d HOUR 4 M			
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Charles				Md.	
10 CITY OR TOWN OF DEATH Freestone Point		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Potomac River		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Student		12b KIND OF BUSINESS OR INDUSTRY At School					
13a USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE Virginia		13b CITY OR TOWN Prince William-Woodbridge		13c INSIDE CITY LIMITS? <input checked="" type="checkbox"/>		13d STREET AND NUMBER 410 G Street					
14 FATHER'S NAME Otis M. Peacher		First Peacher		Middle Peacher		15 MOTHER'S MAIDEN NAME LUCILLE AMIDON		First Peacher		Middle Peacher	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16b SOCIAL SECURITY NO 228-804830		17 INFORMANT LUCILLE AMIDON - WOODBRIDGE		ADDRESS VA					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Drowning DUE TO OR AS A CONSEQUENCE OF Falling from boat Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last 5-18-69 (b) 5-18-69 DUE TO OR AS A CONSEQUENCE OF 5-18-69 (c) 5-18-69											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTR. B.TING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 5-18-69		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell from boat		21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					
21e PLACE OF INJURY (At home, farm, street, factory, building, etc.) Freestone Pt. Woodbridge Va		21f LOCATION Street or R.F.D. No. Freestone Pt. Woodbridge Va		City or Town Freestone Pt. Woodbridge Va		County Freestone Pt. Woodbridge Va					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE E. J. Edelen		EXAMINER'S NAME (Type) E. J. Edelen, M.D. La Plata, Md.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5/21/69		23c. NAME OF CEMETERY OR CREMATORY DUMFRIES		23d. LOCATION (City or Town) DUMFRIES		(County) VIRGINIA		(State)	
24. FUNERAL DIRECTOR CUNNINGHAM MOUNTCASTLE - WOODBRIDGE, VA		ADDRESS		25a REC'D BY REGISTRAR MAY 22 1969		25b REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

4339

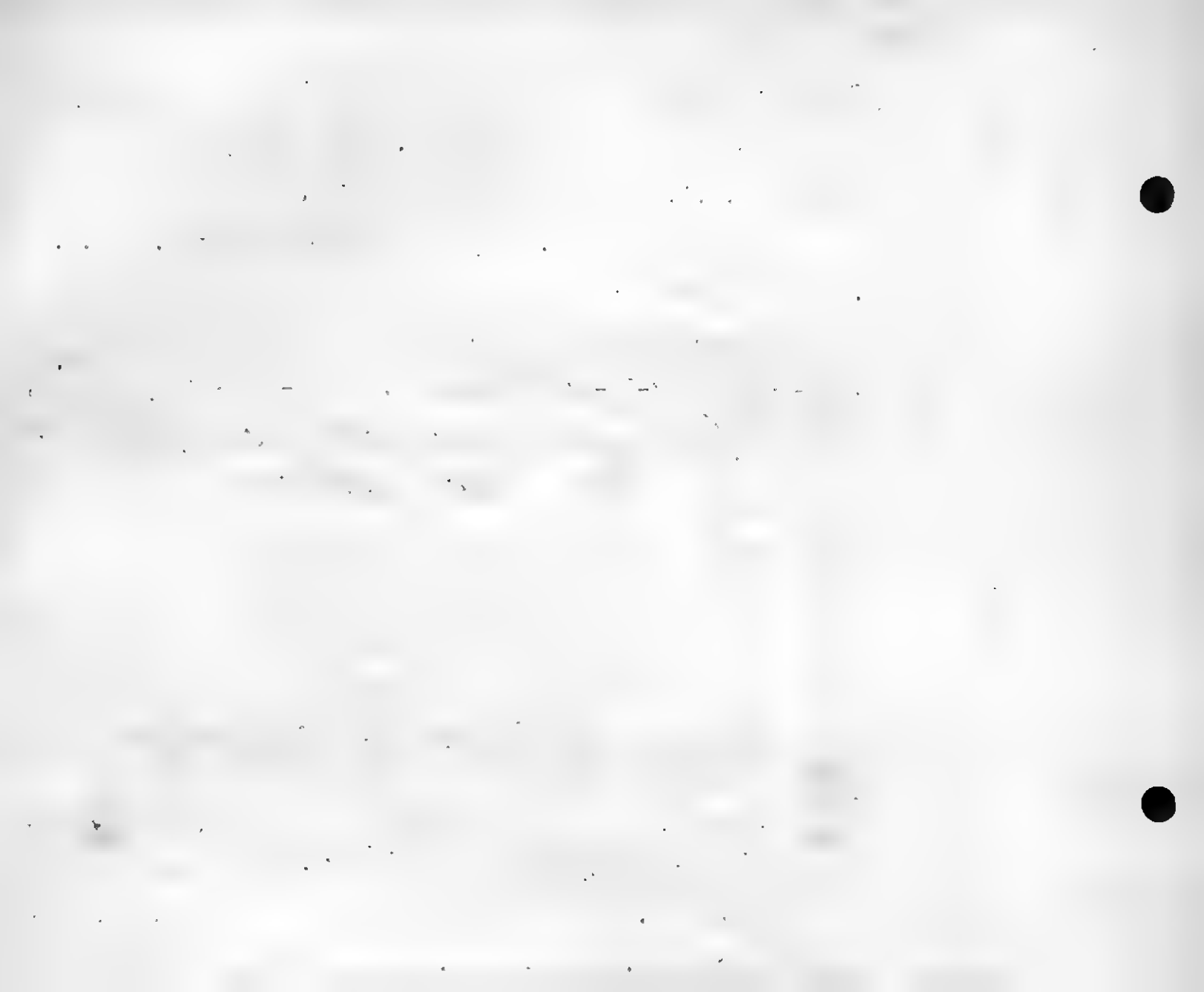
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
06823 CERTIFICATE OF DEATH 06822									
1 DECEASED NAME (Type or print) DOLLIE S. REES			2a. DATE OF DEATH May 27 1969			2b. HOUR 7:55 A.M.			
3. SEX FEMALE		4 RACE Cau		5 DATE OF BIRTH 26 Sept 1889		6 AGE (in years lost birthday) 79 YRS.		7 UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (State or foreign country) Chas. Co. Md		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH CHARLES			
10 CITY OR TOWN OF DEATH LAPLATA		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Physicians Menard		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Domestic			
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Md		13b. COUNTY Chas.		13c CITY OR TOWN Pisgah		13d INSIDE CITY, Md. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Heaven Spring Road	
14. FATHER'S NAME First Middle Last CHARLES D CARPENTER			15. MOTHER'S MAIDEN NAME First Middle Last Sarah A. Bragunier						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b SOCIAL SECURITY NO		17 INFORMANT Son: Clinton Rees		Address Indian Head.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS								2 weeks	
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis								5 years	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11 April 1969 to 27 May 1969 , that (I) (we) lost the deceased alive on 27 May 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Arthur O. Woody		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 27 May 69			
22d. PHYSICIAN'S NAME (Type) ARTHUR O. WOODY, MD		22e. ADDRESS LAPLATA, MD 20646							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-29-69		23c. NAME OF CEMETERY OR CREMATORY Pisgah Meth. Cem.		23d. LOCATION (City or Town) (County) (State) Pisgah, Charles, Md.			
24. FUNERAL DIRECTOR Huntt Funeral Home, Waldorf, Md.				25a. REC'D BY REGISTRAR MAY 29 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06824		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		06823	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print)		First Middle Last JOHN PATRICK ROWAN		2a. DATE OF DEATH Month Day Year 5 27 1969	
3. SEX Male	4. RACE White	5. DATE OF BIRTH June 28, 1920		6. AGE (In years) 48 YRS.	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Charles		10. CITY OR TOWN OF DEATH La Plata			
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, street address) Physicians Mem. Hospital		12a. USUAL OCCUPATION (Kind of work done during last week or last month) Instrument Mech.		12b. KIND OF BUSINESS OR INDUSTRY N.O.S.	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Charles		13c. CITY OR TOWN White Plains	
14. FATHER'S NAME First Middle Last Patrick Francis Rowan		15. MOTHER'S MAIDEN NAME First Middle Last Ellen Foley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. 1942-1945 207-03-4277		17. INFORMANT Address Christa L. Rowan-Wife-White Plains, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) AC. Coronary Occlusion S. v. m. g. DUE TO, OR AS A CONSEQUENCE OF (b) See Aut Sec - DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 5:28 5-28-69 to 5:29 5-29-69, that (I) (we) last saw the deceased alive on 5-26 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE F. J. EDELEN		22c. DATE SIGNED 5-28-69		22d. PHYSICIAN'S NAME (Type) F. J. EDELEN	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/29/1969		23c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery	
23d. LOCATION (City or Town) (County) (State) Chapel Point, Maryland		24. FUNERAL DIRECTOR ADDRESS Arehart Funeral Home, Inc.-La Plata, Md.		25a. REC'D BY REGISTRAR JUN 2 1969	
25b. REGISTRAR'S SIGNATURE Cheney Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06825 Item 23 Film 412 5/15/69 kk		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06824	
1 DECEASED NAME (Type or print) First Middle Last Horace Woodrow Smith			2a DATE OF DEATH Month Day Year May 7 69			2b HOUR 125 A M	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MAY 22, 1912		6 AGE (In years last birthday) 56 YRS.	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CHARLES	
10 CITY OR TOWN OF DEATH LA PLATA		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PHYSICIANS MEM. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE	
13a USUAL RESIDENCE (Where deceased admission) STATE MD.		13b. COUNTY CHARLES		13c CITY OR TOWN WALDORF		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last JAMES EDWARD SMITH			15 MOTHER'S MAIDEN NAME First Middle Last MARY ELLEN BRUNNER				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b SOCIAL SECURITY NO 57810-7991		17 INFORMANT Naomi Richmond, McLEAN, VA. 22101			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure DUE TO, OR AS A CONSEQUENCE OF (b) Hepatic Cirrhosis DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Alcoholism							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Peptic Ulcer Disease with Bleeding							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 11 April, 1969 , to 11 May, 1969 , that (I) (we) last saw the deceased alive on 6 May 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE J. G. Barry Mason MD				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 7 May 69	
22d PHYSICIAN'S NAME (Type) J. G. BARRY MASON				22e ADDRESS LA PLATA, MD. 20646			
23a B. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5-9-69		23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery		23d LOCATION (City or Town) (County) (State) WALDORF, CHARLES, MD.	
24 FUNERAL DIRECTOR HUNTT FUNERAL HOME, WALDORF, MD.				25a REC'D BY REGISTRAR MAY 12 1969		25b REGISTRAR'S SIGNATURE William Judge	

2509

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

06826

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06825

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH			2b HOUR	
VIOLET			TIPPETT	SPALDING		5 Month 19 69			32	
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		Feb. 10, 1895			74 YRS.		MONTHS DAYS HOURS MIN	
7a BIRTH-PLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Charles				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, present if retired.)			12b KIND OF BUSINESS OR INDUSTRY	
La Plata			Physicians Memorial Hosp.			House wife			At Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Md.			Charles		Bel Alton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Frank			Tippett			Mary Elizabeth Shorter				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT Address				
No			218-30-3964D			Mr. John C. Spalding-La Plata, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral</u> DUE TO, OR AS A CONSEQUENCE OF <u>Brain Art Sclerosis</u> (b) <u>Diabetes</u> DUE TO, OR AS A CONSEQUENCE OF <u>Diabetes</u> (c) <u>Diabetes</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5-17-69</u> <u>1955</u> <u>1950</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <u>5/18/69</u> , 19 <u>50</u> , to <u>5/19</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>5/18/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED
<u>E. J. EDELEN</u>										<u>5-19-69</u>
22d. PHYSICIAN'S NAME (Type)						22e ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial		5/22/1969		St. Thomas Manor Cem.		Chapel Point, Md.				
24 FUNERAL DIRECTOR ADDRESS						25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Arehart Funeral Home, Inc.-La Plata, Md.						MAY 22 1969		<u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

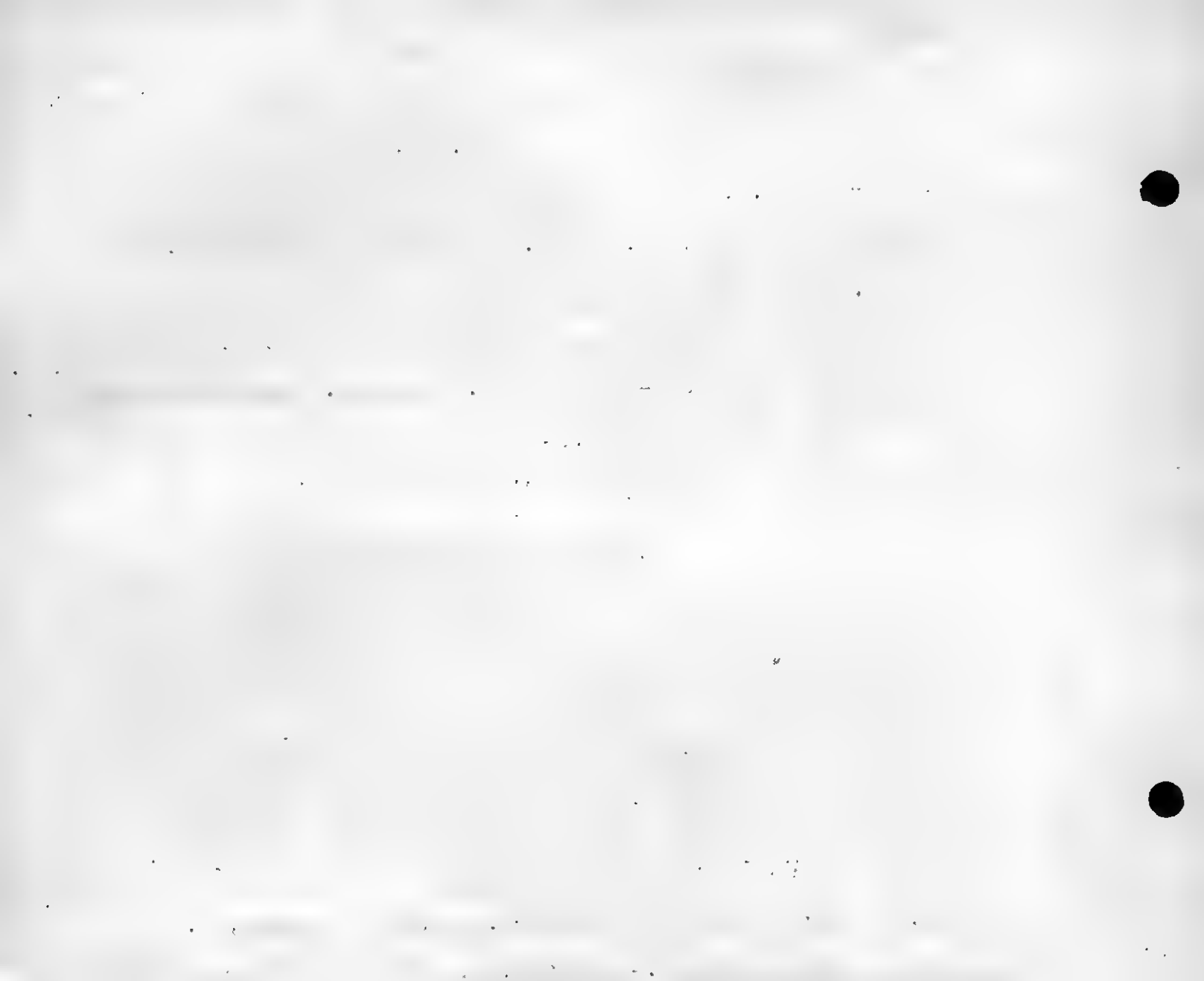
06827

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06826

1. DECEASED-NAME (Type or print) First Middle Last ROSE MARY STANFIELD			2a. DATE OF DEATH Month Day Year May 12 1969		2b. HOUR 9 P M
3 SEX Female	4 RACE White	5. DATE OF BIRTH Aug. 22, 1910		6. AGE (In years last birthday) 58 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Charles Md		
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Physicians Mem. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Cashier	
12b. KIND OF BUSINESS OR INDUSTRY Ed. of Education					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Charles	13c. CITY OR TOWN Hill Top	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER
14. FATHER'S NAME First Middle Last Michael Margiotta		15. MOTHER'S MAIDEN NAME First Middle Last Gilda Scaglione			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 064-10-3478	17. INFORMANT Address Hill Top, Md. Mr. Marvin W. Stanfield-Husband		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Peritonitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ruptured Tubo-Ovarian Abscess Rf.</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 22 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Uremia</u>					
19a. DATE OF OPERATION 4/22/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Tubo-Ovarian		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4/21, 1969, to 5/12, 1969, that (I) (we) last saw the deceased alive on 5/12, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Arturo M. Monteiro		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/13/69	
22d. PHYSICIAN'S NAME (Type) Arturo M. Monteiro		22e. ADDRESS PO Box 807 La Plata, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/15/1969	23c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Gardens		23d. LOCATION (City or Town) (County) (State) Waldorf, Md.	
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc. - La Plata, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 16 1969	25b. REGISTRAR'S SIGNATURE [Signature]



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06828

06827

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year			2b. HOUR			
EARL VAN SUTER						5 22 1969			1:30a			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR	
Male	Colored	June 2, 1947	21 YRS.					May 22 19 69			1:30a	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.			
Maryland		USA				Charles						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
LaPlata			Physicians Memorial Hosp.									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13d. STREET AND NUMBER			
Md.			Charles			YES <input type="checkbox"/> NO <input type="checkbox"/>			Mechanicsville, Md.			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last									
Joseph E. Suter			Mable Delores Mills									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS						
						Joseph T. Suter Mechanicsville, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of the back</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 12:30xx 5 22 19 69			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Subject shot during altercation						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Tavern			21f. LOCATION Street or R.F.D. No. City or Town County State Bills Tavern Mason Mills Charles's Md.						
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)			22b. DATE SIGNED May 23, 1969			
Edward F. Wilson, M.D.												
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			May 16, 1969			St. Josephs Cemetary			Morganza, St. Mary's, Maryland			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
W. Clarke Mattingley Leonardtown, Maryland						DATE MAY 28 1969			Charles Jones			

NOT FOR
RECORD

08882

WILLIAM'S EXHIBIT OF DEATH

1920

May 1920

1920

1920

1920

1920

1920

1920

1920

7123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Mildred			M.		Thorne	5/10/69 Month 10 Day 69 Year			11.00P M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
Female		White		9/4/01		67 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.				Charles Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
LaPlata, Md.			Physicians Memorial			Housewife			Domestic
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Pr. Geo.		Friendly	YES <input type="checkbox"/> NO <input type="checkbox"/>		10501 Old Ft. Rd.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Ralph Payne			Mae Peaper						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
					Clarence Thorne (Son) Same as # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lupus Erythematosus</u> <u>7123</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatoid Arthritis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Mild Valvular Heart Disease</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>6 months</u> <u>2 months</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0		0							
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. ----- 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
				None					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>26 Apr 1969</u> , to <u>10 May 1969</u> , that (I) (we) last saw the deceased alive on <u>10 May 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. DATE SIGNED						
<u>Milton C. Cobey MD</u>			<u>11 May 69</u>						
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
Milton C. Cobey MD			LaPlata, Md.						
23a. BURIAL, CREMATION, OR REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
XXXXXX		May 13-69		Washington National Cem.		Suitland, Maryland			
24. GENERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Simmons Bros		Wash., D.C.		MAY 13 1969		[Signature]			
Simmons Bros. 1661-Gd. Hope Rd. SE. DC									

CS20

10

• •